ATTACHMENT 1

Restricted Psychology Test List

Background and Process

INTRODUCTION

The purpose of this document is to provide information regarding the List of Restricted Psychology Tests mandated by IC 25-33-1-3 (P.L 184-1997) of 1997. Background about the legislative intent of the bill, processes involved in the development of the list, and experiences with the rule making process to date will be addressed. This information is being offered with the intent of providing a context for understanding the procedures, actions, and conclusions of the Indiana Psychology Board in its effort to comply with IC 25-33-1-3.

BACKGROUND

The charge to develop the List of Restricted Psychology Tests is found in IC 25-33-1-3(g) – (j). Legislation enacting this portion of the code was sponsored by Senator Pat Miller and was crafted during the mid-1990s in tandem with modification of IC 25-23.6 to provide for licensure of mental health counselors. In the development of the legislation for licensure of mental health counselors under the Social Worker and Marriage and Family Therapist Board, considerable effort was devoted to the area of defining scope of practice for Mental Health Counselors. The practice acts of these mental health providers groups clearly states that the definitions of "Practice of mental health counseling, practice of marriage and family therapy, and practice of clinical social work does not include diagnosis as defined in IC-25-22.5-1-1.1(c)" (IC25-23.6-1-7.5, IC25-23.6-1-7, IC25-23.6-1-6). Within the context of the delivery of mental health services, only licensed psychologists endorsed as Health Service Providers in Psychology and exempted individuals such as qualified physicians are permitted to independently diagnose and treat mental and behavioral disorders.

Particular attention addressed use of psychological tests and instruments. These devices are by purpose and design inherently involved in the process of diagnosis and treatment planning. Among other considerations the law was based on an agreed distinction between psychological tests used in the practice of psychology in the diagnosis of and treatment planning for mental and behavioral disorders, versus instruments of appraisal utilized by Mental Health Counselors and other mental health professionals in their work as defined in IC 25-23.6. An additional consideration was the education and training of various professions in the use of instruments of various levels of complexity. These distinctions in terms of purpose and complexity were developed to ensure the use of instruments consistent with the scope of practice of each recognized profession.

The result of the negotiations between organizations representing psychology and mental health counseling regarding 1) instruments of appraisal versus psychological tests and instruments, and 2) instruments that introduced a level of complexity for their competent use regardless of purpose, was the decision to call for the development and maintenance of a List of Restricted Psychology Tests. The list was to be under the purview of the Indiana State Psychology Board. Independent use of the instruments on this list would be limited to psychologists licensed at the Health Service Provider in Psychology (HSPP) level or to other appropriately trained mental health professionals working under the supervision of an HSPP. At the same time, language in IC 25-23.6-1-1.5, which regulates social workers, marriage and family therapists, and mental health counselors, identified use of appraisal instruments as appropriately falling within their scope of practice but explicitly prohibited "the use of restricted psychology tests or instruments described in IC 25-33-1-2(1)", which may be used only under "direct supervision of [an HSPP]." IC 25-33-1-3(g)(2.). Further, it was understood that other health care professionals may use some of these tests within the scope of their practice, but may not use them in a manner that constitutes the practice of psychology. Therefore, language was included at IC 25-33-1-3(j) to ensure that these health care professionals would not be restricted when acting within their appropriate scope of practice.

INITIAL PROCESS

As is evident by the considerable length of time elapsed in the process of completing its charge, the Psychology Board found the development of the Restricted Test List to be a task large in scope, complex in nature, and open to various and at times heated differences of opinion. The only guidance provided to the Board in the language of the legislation was that the list should contain those tests and instruments that, "because of their design or complexity, create a danger to the public by being improperly administered and interpreted."

The initial step taken was to identify a process for selection of tests and instruments to be included in the List. The process involved three major phases. First, identification of psychology tests and instruments in print was undertaken. Various texts listing and reviewing tests as well as test publication catalogs were consulted. Even a cursory review of these sources revealed that the number of potential candidates for a test list numbered over two thousand, and that criteria for selection of a subset of tests would be needed. This became the second phase of the test list development project.

Information was sought from test specialists, academic departments of psychology, and practicing psychologists regarding tests most frequently used, or which if misused or misinterpreted, would result in potential harm to the public. In an additional step, attempts were made to gather information from test publishers about their own criteria for level of training required for purchasers of their test products. Unfortunately, this step met with little success, as responses were vague or simply not forthcoming. Furthermore, systems of identifying qualifications for test purchasers vary greatly from publisher to publisher and at times are completely contradictory. For example, two major publishers use a system of initials to identify the level of complexity of their products and suggested

qualifications for purchase. In one case the "A" category includes the least complex instruments, while in another case "A" identifies the most complex items. This phase of list construction allowed a reduction from the potential pool of thousands to approximately three hundred tests.

Third, input was requested from other mental health care provider groups, mental health consumer representatives, and our sister boards regarding the items under consideration for inclusion on the list. The commentary of these groups was most helpful in editing the list, involving some additions as well as deletions. Non-mental health providers potentially impact by the test list provided comments about specific tests that supported their practice, and in many cases these tests were removed from the list. However, the other mental health provider groups objected to every test included on the list and based their objections not on the purpose or technical aspects of specific instruments but rather on the argument that their training and experience allows them to both purchase tests and use them independently. Given the language in their scope of practice statements that clearly defines instruments of appraisal, this argument was not germane to our task and provided little ground for useful discussion. There were understandable differences of opinion, not all of which could be successfully resolved.

PRINCIPLES OF LIST CONSTRUCTION

The overarching principle guiding list construction was the concept that the use of psychological tests, in this context, is part of a complex assessment process, the purpose of which is to yield accurate and useful information for guiding interventions with those for whom the tests are utilized. According to the American Psychological Association's Report of the Task Force on Test User Qualifications (APA, 2000), assessment is a complex process of data gathering and decision-making involving a number of highly skilled activities including the following:

1. recognizing the nature of the decision to be made or the question to be addressed;
2. deciding what information needs to be gathered to answer relevant questions and to make competent decisions;
3. selecting reliable and valid methods of acquiring such information including tests, interviews, observations, surveys or other data gathering techniques;
4. competently administering and scoring such assessment procedures or collecting such information;
5. accurately interpreting information including the knowledge of when to question the technical interpretation of a procedure because of some intervening or mitigating circumstances;
6. translating the assessment data and resultant interpretation into a professionally sound decision.

On the surface, some psychological tests appear quite simple, with administration involving a few directions to the test taker, while scoring and interpretation may seem to include only the reading of a computer generated report of scores and findings. It is precisely this deceptive simplicity that leads to the possibility of misuse,

misinterpretation, and potential harm when the purposes and processes of psychological testing are not fully understood and applied.

The first principle underlying selection of test list items arose from an attempt to identify tests that, due to frequency of use or nature of data produced by the test, lead to very significant decisions that have direct and long lasting impact the lives of Indiana citizens. When psychological tests are not correctly chosen, applied, and interpreted within the context of the cultural, physical, intellectual and literacy abilities of the test taker, the test process may result in: inappropriate or inadequate medical or mental health diagnosis and/or treatment; decisions affecting admission or exclusion from educational, social service, rehabilitative programs, and employment; decisions impacting family law such as custody, visitation, foster placement, or termination of parental rights; and decisions involving the criminal justice system.

A second principle guiding list construction was the recognition that there are tests and instruments that may be classified as psychological tests but which do support the practice of non-psychologists. When a clear distinction was possible, these tests were omitted from the list. A conscientious effort was made to avoid intruding upon or inadvertently appearing to restrict other health care professionals operating appropriately within their scope of practice.

ORGANIZATION OF THE TEST LIST

For purposes of clarity the list was divided into seven categories including:

1. intelligence tests;
2. tests of personality and psychopathology;
3. neuropsychological tests;
4. tests of learning ability and school readiness;
5. projective tests;
6. inventories and rating scales;
7. adaptive behavior scales.

For inclusion on the list, each test or instrument had to be a device used to support the diagnosis, classification, treatment planning, or prediction of treatment outcome in at least one of the following areas:

1. intelligence, reasoning, memory, perception, language, and other higher cognitive functions;
2. psychiatric disorders recognized by the Diagnostic and Statistical Manual, Fourth Edition (DSM-IV);
3. enduring personality traits;
4. emotional states;
5. psychosocial effects of physical illness, accident, injury, or disability.

In addition, to be included on the list each test also had to meet at least one of the following technical criteria:

1. sample of behavior obtained under controlled, standardized circumstances;
2. continuously scaled or criterion referenced raw score that requires reference to one or more normative bases for interpretation;
3. factorially complex or multidimensional in nature;
4. interpretation dependent upon reference to empirical studies of the instrument's psychometric properties or reliability and validity;
5. projective technique measuring automatic, unconscious processes that influence personality and behavior.

PROCESS TO DATE

The development of the draft list took several months, involving the time and effort of volunteer consultants, as well as that of all board members, both current and some now retired from board service. During the list construction phase, input was requested from psychologists, test experts, test publishers, representatives of other health professions, and our sister boards. Thoughtful consideration was given to the comments and concerns raised and led to the modification of the list when appropriate.

In 1998, a draft of the Restricted Test List was distributed to interested parties for comment. Upon review of comments, further modifications were made which resulted in another substantial reduction in the number of tests on the list. The draft rule was then developed and published, and a public hearing was held on March 16, 2001. Several groups and individuals gave testimony. While some of the comments were in support of the list, most were in opposition to the list as a whole or to specific items on the list. Before this input could be given adequate consideration, the Psychology Board was informed that there was a technical problem involving the timing of one aspect of the rule making process, and the decision was made to withdraw the rule at the April 20, 2001 Psychology Board meeting.

In the fall of 2001, the Psychology Board took up the issue of the Restricted Test List once again. Under the advice of board counsel, the rule making process was initiated following the procedures for proper notice, call for public comment, etc. After reviewing the testimony received during the earlier attempt at rule making, it was the decision of the Board to leave the Test List largely intact as there was a lack of convincing evidence for modification. Further discussions were held with interested parties, but the position of other mental health provider groups remained fixed in opposing the list as a whole rather than addressing the merits of particular items on the proposed list.

Public comment was received for several weeks, some of which arrived past the published deadline for submission. Every effort was made to give these comments serious consideration. A written response was sent to all parties. The public hearing for the proposed rule was scheduled for September 2003, but due to the untimely death of Governor O'Bannon, the hearing was postponed until January 2004.

Testimony received throughout the comment period as well as at the public hearing produced little new information and was consistent with the themes expressed during the first rule development attempt. Due to continuing concern expressed by groups potentially affected by the Restricted Test List, two meetings were organized by members of Governor Kernan's staff, Mr. Tom McKenna and Ms. Colleen Shere. These meetings took place at the Indiana State House on March 10 and 25, 2004. Representatives from the Indiana Psychology Board as well as interested groups attended.

There was clarifying discussion of both the Board's position and efforts in developing the test list, as well as a review of the concerns of the other parties. It was agreed that the Board would work to include language in the rule that would further clarify its intent to not intrude on the legitimate practice of other non-mental health professionals when appropriate use of instruments on the test list would be support their practice and not constitute the practice of psychology. However, at the Psychology Board meeting held on April 2, 2004, the board was advised by counsel in consultation with the state's Attorney General's Office that inclusion of such language was ill-advised because it failed to provide any additional legal protection for these concerned groups and would potentially create difficulty in the rule promulgating process. The Board once again confirmed its understanding that the Restricted Test List applies to other providers of mental health services as referenced above and is not intended to intrude upon the legitimate practice of other health professions.

Other mental health provider groups continued to advance the argument that they believe that unsupervised use of all tests and instruments on the list is within their domain due to ability to purchase these tests and because many of their members have had training and experience in the use of tests. Once again, there was no evidence provided that allowed review of individual items on the list to determine if they better meet the definition of instruments of appraisal rather than psychological tests.

Finally, the other mental health provider groups argued that the board had not shown that the tests on the proposed list constitute harm to the public if administered by someone other than a psychologist. It is the board's opinion that this phrasing of the question of potential harm is misleadingly narrow and fails to recognize the essential issue. The test itself is not what constitutes danger; rather, it is the serious consequences to people's lives that may occur if the information generated through testing is inaccurate or inappropriately applied. A sample of actual clinical examples of harmful outcomes associated with improper test use is included in this packet (Attachment 2).

CONCLUSION

This document is being offered in an effort to clarify the conceptual approach, steps taken, and assumptions underlying the construction of the Restricted Psychology Test List mandated by IC 25-33-1-3. The Board sincerely appreciates the input and assistance received from concerned groups and individuals, and is hopeful that the rule making

process will go forward toward the final goal of providing safe and professional mental health services of the highest possible quality to the citizens of Indiana.